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Paulino-Grisham, Smith, & Chmielarz, P.A.

June 20, 2014

Sent Via U.S. Mail and Facsimile: (202) 659-4503
Alvaro I. Anillo
1701 Pennsylvania Avenue, N.W.
Washington, D.C. 20006-5811

RE: Darren Mickell

Dear Mr. Anillo:

Please be advised that it is not the intent of Mr. Mickell or this office to unreasonably delaythe evaluation of Darren Mickell's claim for disability benefits under the Plan (as he is in great need of the benefits as soon as possible); however, because we have been advised that his claim is being administered under ERISA, it is imperative that Mr. Mickell submit all information and documents in support of his claim during the appeal process so that the Disability Claims Committee can fully and fairly evaluate his claim. Further, may I remind you that it took several requests to the NFL to obtain a copy of Mr. Mickell's claim file and then a significant amount of time to obtain medical records for the years he was in the NFL, as they were not included with the claim file documents you sent.

Additionally, the request to review Dr. Chaim Arlosoroff's report is not unreasonable as the Disability Claims Committee will most certainly give his report a great deal of weight when making a determination in this matter. Of note is that Dr. Arlosoroff did not review the extensive medical documents provided just prior to Mr. Mickell's evaluation. As you know, there was not a great deal of time to get these records to you based on the short notice of the *Neutral Physician Appointment* (IME); however, we did expect that this information would be provided to Dr. Arlosoroff following his examination of Mr. Mickell. Certainly Mr. Mickell's medical history is pertinent to any medical evaluation. Please advise if Dr. Arlosoroff plans on reviewing the medical records and supplementing his report or if his opinion will be based solely on his very brief examination of Mr. Mickell. Following the examination by Dr. Arlosoroff, Mr. Mickell contacted my office quite upset that Dr. Arlosoroff spent less than 30 minutes with him, including the time spent discussing Mr. Mickell's background and medical history. According to Mr. Mickell, Dr. Arlosoroff was in a hurry and spent very little time actually examining him. While Dr. Arlosoroff may dispute this assessment of his examination, had you allowed the examination to be videotaped per Mr. Mickell's right under Florida law, the extent of the examination would have been documented.

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Claimant: Darren Mickell

Because it is important for any evaluating physician to fully understand a patient's medical history, **please allow this to serve as Mr. Mickell's request that all medical information, records and reports included with the letter to you dated June 30, 2014, including the reports from Dr. Lichtblau and Dr. Todd, be sent to the physicians hired to evaluate Mr. Mickell at the request of the NFL and the Disability Claims Committee** (the *Neutral Physician Appointments).*

Regarding the Neutral Physician Appointments scheduled by the Disability Claims Committee for August 4th and 5th in Atlanta, please note that Mr. Mickell has two children for whom he is responsible and two weeks' notice to leave town for 2 or 3 days, without any prior notice, was quite difficult. Additionally, as the result of Mr. Mickell's medical conditions and limitations, extensive travel for such a short time is very difficult. Mr. Mickell is more than willing to attend reasonably scheduled IMEs per his obligations under the Plan, but he is entitled to sufficient notice and an attempt should be made to limit Mr. Mickell's need to travel as much as possible. Moreover, there are ample qualified physicians in the South Florida area. There does not seem to be a valid reason to make Mr. Mickell fly to Atlanta for at least two days when there are numerous board certified neurologists, psychiatrists and psychologists in the South Florida area. Also, I reminded Megan Anderson that Mr. Mickell is represented by counsel; therefore **all requests for information, documents, appointments, examinations, et al should be directed to my office and not Mr. Mickell. Please note for your file that Mr. Mickell is not to be directly contacted by your office, the Plan's office, The Disability Benefits Committee, Ms. Anderson or any of their representatives.** I will be more than happy to work with Ms. Anderson to find a mutually convenient time for Mr. Mickell to attend all reasonable IMEs.

Your letter of July 17, 2014 stated that Mr. Mickell's neuropsychological impairment was raised for the first time in the June 30th letter. As you know, Mr. Mickell previously applied for benefits on his own and was quickly denied for an incorrect reason. Thus, he was not provided with the opportunity to fully explain his numerous medical conditions and limitations. However, because on appeal you provided him with sufficient time to obtain his medical records and fully explain his health, the extent of his disability was explained in the June 30th letter, including the cognitive problems he sustained as the result of years of playing football for the NFL.

Finally, we are objecting to a second neuropsychological examination so close in time to the previous one. The psychological literature is clear that additional neuropsychological testing in such a short period of time poses a great danger to invalid results due to the Retest Effect (often referred to as the "Test Retest Effect"). Research has shown that undergoing a second examination so close in time to the first evaluation is cause for concern due to the substantial

Claimant: Darren Mickell

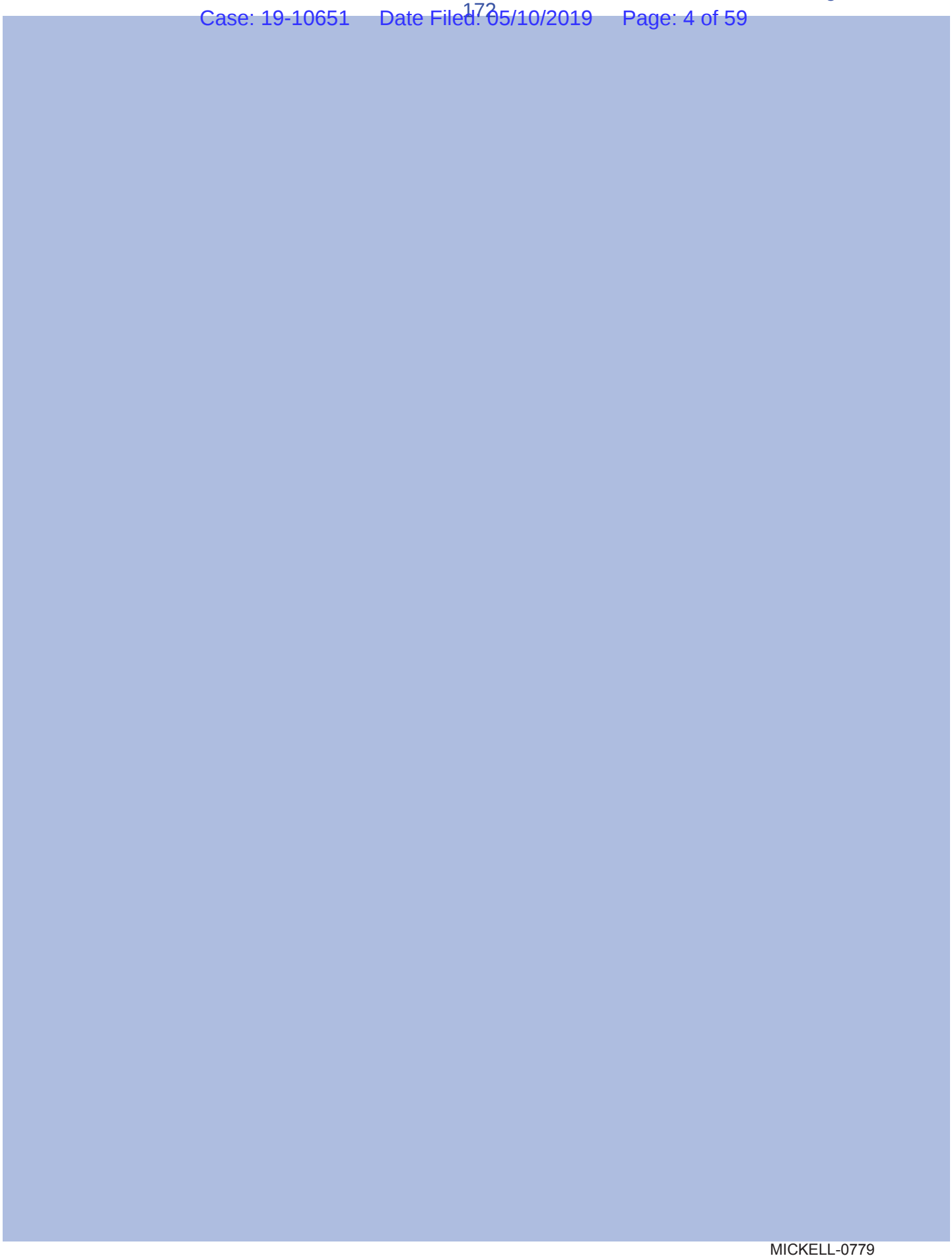
practice effect or even "test-wise" behavior (he is now quite familiar with the testing process). These variables would be expected to lead to improvement in his scores, and could result in scores interpreted as "normal" performance when in reality it is a test-retest effect. Clearly there is a significant danger that additional neuropsychological testing will result in invalid results. Moreover, you are requesting that Mr. Mickell submit to testing by a psychologist that requires him to travel by plane to another state. A basic search for neuropsychologists in Mr. Mickell's area reveals that there are numerous psychiatrists and psychologists available that perform and are qualified to perform neuropsychological testing. Accordingly, it is highly suspect that the Disability Claims Committee would fly Mr. Mickell to Atlanta, put him up in a hotel for 1or 2 nights, and pay for his meals when there are numerous, qualified neuropsychologists in the South Florida area. It is important to point out that under Florida law (which can still be applied in ERISA claims), it is considered bad faith claims handling practice to choose and rely upon a physician that is not truly independent. Thus it is requested that the Disability Claims Committee reassess its request for additional neuropsychological testing, given the dangers of invalidity in the test results.

I look forward to your response. Should you have any questions or wish to further discuss this matter, please do not hesitate to contact me at (954) 989-9000.

Very truly yours,

Mindy L. Chmielarz, Esquire
For the Firm

cc: Paul Scott



DI LAW GROUP

Paulino-Grisham, Smith, & Chmielarz, P.A.

June 30, 2014

Sent Via U.S. Mail & Facsimile: (410) 783-0041
Retirement Board for the
Bert Bell/Pete Rozelle NFL Player Retirement Plan
Attn.: Paul Scott, Director of Disability Benefits
on behalf of the Disability initial Claims Committee
200 St. Paul Street, Suite 2420
Baltimore, MD 21208-2008

RE: Darren Mickell- Supplemental Information for Total and Permanent Disability Benefits Claim

Dear Mr. Scott:

As you are aware, this Firm represents Darren Mickell in his claim for Total and Permanent ("T&P") Disability Benefits under the terms of the Bert Bell/Pete Rozelle NFL Player Retirement Plan (the "Plan"). This correspondence and the information annexed hereto, as well as all information previously provided, serve as supplemental information to Mr. Mickell's formal appeal and response to the September 27, 2013 denial letter (the "Denial Letter"), which denied Mr. Mickell his right to total and permanent disability benefits in the above-referenced matter.[1] Mr. Mickell's Appeal was timely filed as of March 11, 2014. However, due to delays in providing the undersigned with a copy of the Claim File and Plan documents and problems obtaining Mr. Mickell's medical records from the football teams for which he played as well as from the physicians with whom he most recently treated, Alvaro Anillo, Esquire, in his capacity as the Plan's legal representative, advised Mr. Mickell that his claim will remain open until all documents to be reviewed as part of the appeal have been submitted.[2] The undersigned continuously advised Mr. Anillo of the ongoing delays in obtaining medical records. In response, Mr. Anillo continued to reassure the undersigned that the appeal review will not commence or be completed until all information has been provided.[3]

Brief History of Claim:

Mr. Mickell played professional football for the National Football League ("NFL") from 1992 to 2001 for several teams including Kansas City, New Orleans, San Diego, and Oakland. During Mr. Mickell's tenure with the NFL, Mr. Mickell sustained serious injuries, but continued to play football for as long as possible. Mr. Mickell's first

[1] A copy of the Denial Letter is attached to this Appeal as Exhibit "1".
[2] A copy of the March 11, 2014 letter confirming the ongoing extension to provide supplemental information is attached to this Appeal Letter as Exhibit "2".
[3] A copy of correspondence regarding the delays and ongoing extension is attached to this Appeal Letter as Exhibit "3".

significant injury occurred in 1994 to both knees while playing for Kansas City. During the 1994 season, the team physicians did what they could to alleviate the pain and keep Mr. Mickell in the game; however at the end of the season he had surgery on both knees. Just prior to the surgery, Mr. Mickell was given an injection in his back, which he understood would allow him to remain awake throughout the entire procedure. Apparently, something went wrong and he was put to sleep for the surgery. When he woke-up following the surgery, his back pain was worse than his knee pain. He was treated for both problems with pain management treatments. Mr. Mickell continued to play football for the NFL.

In 1996, Mr. Mickell had surgery on his right shoulder due to an injury sustained during the years he played with New Orleans. In 1999, he injured his left hip while playing for the San Diego Chargers. His hip was drained several times, but the pain never resolved and became worse as he continued to play.

Throughout the last two years of his career Mr. Mickell was given cortisone shots and other pain numbing injections to alleviate the pain in his back, knees and hips; and he was also prescribed inflammatory medications to be taken daily. While the medication and injections numbed his pain enough to allow Mr. Mickell to play another two years; by the end of 2000 he was forced to stop playing due to significant pain and limitations. At that time it also became apparent that he suffered cognitive deficiencies as the result of his years in the game. He had noticeable short term memory loss, great difficulty staying focused, problems controlling his emotions and anger, and chronic headaches.

Unfortunately, time away from the game and a sedentary lifestyle did not improve his physical or mental condition. For years after leaving the NFL, Mr. Mickell could not work in any capacity due to daily, constant headaches, as well as severe pain and limitations in both shoulders; chronic, stabbing pain down his back; constant hip pain; and achiness in both knees. Over the next few years the pain worsened and he had great difficulty just functioning and getting through the day. Mr. Mickell's cognitive functionality deteriorated as well.

In April 2012 due to family obligations, Mr. Mickell felt he had no choice but to find work. He attempted to work for about 1 ½ years and finally had to stop due to physical pain and weakness as well as his cognitive limitations. It should be noted that prior to beginning his football career with the NFL, Mr. Mickell was a college student at the University of Florida. He took great pride in his studies and did rather well as he had a good memory and no problems with focus and concentration.

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Claimants name: Darren Mickell
Appeal of T&P Benefit Denial

Long Term Disability Plan Language

Under the clear, express terms of the Plan Mr. Mickell is entitled to total and permanent disability benefits because he is substantially prevented from and substantially unable to engage in any occupation or employment for remuneration or profit; his condition is permanent; and his total and permanent disability is football degenerative as it arose out of League football activities and while he was an *active Player* with the NFL.

Relevant Provisions from the Plan include the following:

5.1. Eligibility

An Eligible Player whose application for total and permanent disability ("T&P") benefits is received by this Plan on or after September 1, 2011, who is determined by the Retirement Board or the Disability Initial Claims Committee to be totally and permanently disabled in accordance with Section 5.2, and who satisfies the other requirements of this Article 5, will receive a monthly T&P benefit in the amount described in Section 5.5 for the months described in Sections 5.8 and 5.9

5.2 Determination of Total and Permanent Disability

(a) General Standard. An Eligible Player who is not receiving monthly retirement benefits under Article 4 or 4A will be deemed to be totally and permanently disabled if the Retirement Board or the Disability Initial Claims Committee finds (1) that he has become ***totally disabled*** *to the extent that he is* ***substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit****, but expressly excluding any disability suffered while in the military service of any country, and (2)* ***that such condition is permanent****. The educational level and prior training of a Player will not be considered in determining whether such Player is "unable to engage in any occupation or employment for remuneration or profit.:* ***A Player will not be considered able to engage in any occupation or employment for remuneration or profit*** *within the*

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meaning of this Section 5.2 ***merely because such person*** *is employed by the League or an Employer, manages personal or family investments, is employed by or associated with a charitable organization, is employed our out benevolence, or* ***receives up to $30,000 per year in earned income.*** *A disability will be deemed to be* ***"permanent" if it has persisted or is expected to persist for at least twelve months from the date of its occurrence,*** *excluding any reasonably possible recovery period.*

5.3 Classification

Each Player who is determined to be totally and permanently disabled in accordance with Section 5.2 will be awarded benefits in one of the four categories below.

(a) Active Football. Subject to the special rules of Section 5.4, Players will qualify for benefits in this category if the disability(ies) results from League football activities, arises while the Player is an Active Player, and causes the Player to be totally and permanently disabled "shortly after: the disability first arises.

(b) Active nonfootball. Subject to the special rules of Section 5.4, Players will qualify for benefits in this category if the disability(ies) does not result from League football activities, but does arise while the Player is an Active Player and does cause the Player to be totally and permanently disabled "shortly after: the disability(ies) first arises.

(c) Inactive A. Subject to the special rules of Section 5.4, Players will qualify for benefits in this category if a written application for T&P benefits or similar letter that began the administrative process that resulted in the award of T&P benefits was received within fifteen (15) years after the end of the Player's last Credited Season. This category does not require that the disability arise out of League football activities.

(d) Inactive B. All players who are determined to be totally and permanently disabled in accordance with Section 5.2 but who do not qualify for categories (a), (b), or (c) above will be awarded

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benefits in this category. This category does not require that the disability arise out of League football activities.

(e) *"Shortly After" Defined. A Player who becomes totally and permanently disabled no later than six months after a disability(ies) arises will be conclusively deemed to have become totally and permanently disabled "shortly after" the disability(ies) first arises, as that phrase is used in subsections (a) and (b) above, and a Player who becomes totally and permanently disabled more than twelve months after a disability(ies) first arises will be conclusively deemed not to have become totally and permanently disabled "shortly after" the disability(ies) first arises, as that phase is used in subsections (a) and (b) above. In cases falling within this six to twelve-month period, the Retirement Board or the Disability Initial Claims Committee will have the right and duty to determine whether the "shortly after" standard is satisfied.*

(f) *"Arising out of League football activities" means a disablement arising out of any League pre-season, regular season, or post-season game, or any combination thereof, or out of League football activity supervised by and Employer, including all required or directed activities. "Arising out of League football activities: does not include, without limitation, any disablement resulting from other employment, or athletic activity for recreational purposes, nor does it include a disablement that would not qualify for benefits bur for an injury (or injuries) or illness that arises out of other than League football activities.*

5.5 Amount of Monthly Benefit.

An Eligible Player who is awarded T&P benefits will receive the following monthly amount for the months described in Sections 5.8 and 5.9. The monthly payment determined below will be offset by any disability benefits provided by an employer

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other that the League or an Employer, but will not be offset by worker's compensation.

(a) Amount. Unless modified by Sections 5.5(b), (c), (d), or (e) below, the amount of the monthly benefit will equal the sum of Total Credits including, if applicable, the Benefit Credit and any Legacy Credit for the Plan Year in which such total and permanent disability occurs.
(b) Minimum Amounts.

Category	*Effective 9/1/2011*	*Effective 1/1/2016*	
Active Football	*$4,000*	*$4,000*	
Active Non Football	*$4,000*	*$4,000*	
Inactive A	*$4,000*	*$4,000*	
Inactive B	*$4,167*	*$5,000*	

Under the terms of this Plan, if Mr. Mickell can provide sufficient evidence to show that as the result of League football activities he is unable to engage in any occupation or employment for remuneration or profit as specifically stated under Article 5 of the Plan, then he is entitled to Total and Permanent Disability Benefits. The information and documents contained in this Appeal Letter provide strong proof that due to the effects of the substantial injuries sustained by Mr. Mickell during his eight seasons with the NFL, he has remained totally and permanently disabled.

The Disability Claims Committee has violated the Claims Procedure and Notice Requirements Under the Plan and ERISA

Section 12.6 of the Plan sets forth the procedures that must be followed if a claim for disability benefits under Articles 5 and 6 of the Plan is wholly or partially denied. In

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accordance with the Plan a *notice of adverse determination will be written in a manner calculated to be understood by the claimant and will set forth the following:*

(1) The ***specific*** reason(s) for the adverse determination;

(2) Reference to the ***specific*** **plan provisions** on which the determination is based;

(3) A description of additional material or information, if any, needed to perfect the claim ***and the reasons such material or information is necessary***;

(4) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;

(5) Any **internal rule, guideline, protocol, or other similar criterion relied on in making the determination**, (or state that such information is available free of charge upon request;

(6) If the determination was based on a scientific or clinical exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's circumstances (or state that such explanation is available free of charge upon request).

The Claimant will have 180 days from the receipt of an adverse determination to file a written request for review of the initial decision to the Retirement Board.[4]

According to the Retirement Plan documents provided at Mr. Mickell's request, the Plan may also be guided by ERISA which too sets certain ***minimum*** requirements for procedures and notification when a[n] . . . administrator denies a claim for benefits.[5]

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[4] As noted, Mr. Mickell filed his written request for review in a timely manner and was provided additional time to submit documentation in support of his Appeal and right to total and permanent disability benefits under the Plan.

[5] ERISA sets certain ***minimum*** requirements for procedures and notification when a[n] . . . administrator denies a claim for benefits. ERISA requires that specific reasons for denial be communicated to the claimant and that the claimant be afforded an opportunity for 'full and fair review' by the administrator. Section 1133, 29 U.S.C. § 1133, reads as follows:

> In accordance with regulations of the Secretary, every employee benefit plan shall-
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the **specific reasons for such denial**, written in a manner calculated to be understood by the participant, and

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The Denial Letter is lacking on its face in terms of complying with these clear notice requirements. It merely cites portions of some of the relevant plan provisions and includes a 3 sentence discussion as to why benefits were denied. Specifically, Mr. Scott stated the following as the **sole** reason for the denial of benefits by the Disability Initial Claims Committee ("the Committee"):

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(2) afford **a reasonable opportunity** to any participant whose claim for benefits has been denied **for a full and fair review** by the appropriate named fiduciary of the decision denying the claim."[5]

The ***minimum*** claims procedure requirements under ERISA set forth the following requirements for the notification of an adverse benefit determination"[5]:

(1) [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination . . . . The notification ***shall*** set forth, in a manner calculated to be understood by the claimant –

(i) The ***specific*** reason or reasons for the adverse determination;

(ii) Reference to the ***specific*** **plan provisions** on which the determination is based;

(iii) A description of ***any*** additional material or information necessary for the claimant to perfect the claim ***and an explanation of why such material or information is necessary;***

(iv) **A description of the plan's review procedures and the time limits applicable to such procedures**, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) **If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination**, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other **criterion will be provided free of charge to the claimant upon request** . . . .

The Courts make clear that these ***minimal*** claims procedure requirements under ERISA "***are designed to afford the beneficiary an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial.***" *Halpin*, 962 F.2d at 689 (*citing Brown v. Retirement Committee of Briggs & Stratton Retirement Plan*, 797 F.2d 521 (7th Cir. 1986) when it goes on to state "[t]he persistent core requirements of review intended to be full and fair including knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties reaching and rendering his decision."). In determining whether an administrator has complied with ERISA's claims procedure requirements, the Court asks, ***"[w]as the beneficiary supplied with a statement of reasons that, under the circumstances of the case, permitted a sufficiently clear understanding of the administrator's position to permit effective review?"*** *Schneider*, 422 F.3d at 628 (*citing Halpin*, 962 F.2d at 690).

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> *On September 27, 2013* ***the Committee denied your application for T&P benefits because you are currently employed****. The Committee determined that your current employment is not associated with the League or an Employer, personal or family investments, a charitable organization, or out of benevolence. Therefore, the Committee found that you are not totally and permanently disabled under the Plan section 5.2(a).*

What the Committee failed to consider or confirm is whether or not Mr. Mickell had received (or would likely receive) in excess of $30,000 per year in earned income. Had the Committee contacted Mr. Mickell's employer regarding his earnings they would have learned that he was expected to earn less than $30,000 per year in earned income. As that appears to be the only basis for the denial of benefits, arguably, Mr. Mickell only has to show that he received less than $30,000 per year in earned income in order for his benefits to be approved. However, in an abundance of caution, Mr. Mickell is also submitting medical information confirming that he is substantially prevented from and substantially unable to engage in any occupation or employment for remuneration or profit; his condition is permanent; and his total and permanent disability is football degenerative as it arose out of League football activities and while he was an *active Player* with the NFL..

MR. MICKELL RECEIVED LESS THAN $30,000/YEAR IN EARNED INCOME

At the time of his disability, Mr. Mickell was employed by Freight Handlers, LLC in the Publix Deerfield Distribution Center in Deerfield.[6] As indicated in the letter from Lisa Howard, Human Resources Generalist for Freight Handlers, LLC, Mr. Mickell worked between 30 and 40 hours each week. What Ms. Howard did not include in her correspondence was Mr. Mickell's hourly wage and the number of times he was absent from work or had to leave early as the result of the injuries he sustained while a player for the NFL. Moreover, the Committee had in its possession an Earnings Statement from August 15, 2013 which showed that as of August 8, 2013 Mr. Mickell had earned $17,221.65.[7] That averages to approximately $538.17 per week in earned income. In light of the fact that there were less than 22 weeks left in the year and Mr. Mickell explained in his application for T&P benefits that he was not able to work as the result of his injuries, it appeared quite likely that Mr. Mickell would not earn an additional $12,778.35 by the end of the year.

[6] Correspondence form FHI, LLC verifying his employment is attached to this Appeal Letter as Exhibit"4".
[7] A copy of the ADP Earnings Statement for Pay Period ending 08/15/2013 is attached to this Appeal Letter as Exhibit "5".

Mr. Mickell's tax return shows that he earned only $23,535 in 2013. In 2012 he earned $21,886.00, significantly less than the $30,000 per year threshold.[8]

MEDICAL REVIEW

As the direct result of injuries sustained while an active member of the National Football League, Mr. Mickell sustained significant injuries resulting in symptoms, restrictions, and limitations which have prevented him from being able to substantially engage in any occupation or employment for remuneration or profit (up to $30,000.00 per year). Following is a detailed breakdown of those symptom's, restrictions and limitations:

- Memory problems
- Inability to concentrate
- Word Loss
- Problems with focus
- Problems processing information and following directions
- He tires easily – due to chronic pain, headaches, and inability to sleep due to pain and racing mind
- Chronic headaches – daily. Nothing really helps. Some days they are worse than others. He can't figure out what sets them off, they just come and go
- Neck pain down the middle of his neck – worse with activity. It's always there, but if he is active then the pain becomes debilitating.
- Bilateral shoulder pain - surgery on both shoulders from time in NFL. Reaching overhead is extremely difficult and painful. Also, lacks range of motion.
- Low Back Pain – chronic and its always achy, but the pain is unbearable at times. After being out or at work for several hours the pain became excruciating. He was sent home early a few times due to pain and his inability to perform any work activity.
- Left Hip Pain which makes walking and standing painful. Sharp pains in his hip that "buckle" him.
- Sitting for prolonged periods is very painful due to hip, low back and knee pain. Once pain hits very difficult to find relief. He needs to lie down often for several hours and take a muscle relaxant
- Bilateral knee pain. Chronic and severe all the times. Walking for a long time, going up and down steps and standing for too long results in unbearable pain and his knees will swell.

[8] A copy of Mr. Mickell's 2012 & 2013 tax returns are attached to this Appeal Letter as Exhibit "6".

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- A number of dislocated fingers make it difficult to grasp and use his right hand for anything involving fine motor skills.

Mr. Mickell's application for Total and Permanent Disability Benefits provides the following conditions that prevent Mr. Mickell from working: (1) knees (bilateral) – no cartilage, stiffness and occasional swelling; (2) Right hip – major pain and numbness; (3) lower back; and (4) Shoulders (bilateral) – pain. Mr. Mickell's claim also provides that the injuries to his knees, hip and lower back occurred while playing football. The evidence also supports that Mr. Mickell's shoulder injuries were caused by playing football.

Mr. Mickell was diagnosed with chondromalacia of the patella of his left knee in 1992. He also began to suffer from effusion and mild thinning of the cartilage. In 1994, he was diagnosed with bilateral chondromalacia of the patella. The records indicate that he continued to suffer from bilateral knee pain and stiffness throughout his career, suffering MCL and patella sprains in 1994 and 1996 respectively. The MRI conducted on April 5, 2014 showed small effusions in both knees as well as grade II osteochondral injuries.

In September of 2000, the records first indicate that Mr. Mickell complained of pain in his right hip, suggestive of chondromalacia in the hip. The records are silent regarding hip injury other than this one incident. An MRI of the left hip in April of 2014 shows an anterior left acetabular labral nondisplaced tear and mild osteoarthritic change in both hips.

In 1992, the KC Chiefs noted that Mr. Mickell had a history of back issues but provide no explanation for this statement and no further mention of any back pain is mentioned for two years. In 1994, he suffered a blow to his back during a game resulting in swelling of the lumbosacral paraspinal muscle. On June 26, 1996, Mr. Mickell was diagnosed with disc protrusion at the L4-L5 disc. In 1999, Mr. Mickell was suffering from lumbosacral strain, suggestive of degenerative disc disease. The April 2014 MRI shows disc herniation at the C5-C6, C6-C7, L4-L5, and L5-S1 discs. There was also disc desiccation at the C2-C3 and C3-C4 discs. C4-C5 showed a small disc/osteophyte bulge with early degeneration.

Mr. Mickell developed bilateral shoulder pain in 1993, including a right rotator cuff strain suffered in a game. In 1995, Mr. Mickell suffered a left shoulder injury resulting in tingling and numbness in his fingers and causing limited motion. An MRI revealed a tear of the posterior joint capsule and posterior glenoid labrum. He injured his right shoulder in training camp in August of 1997. An MRI suggested multi-directional instability, impingement syndrome, and partial tear of rotator cuff. He reinjured the shoulder in a game in 1997 straining the rotator cuff. In 1998, he had surgery on his right shoulder, causing him to miss the entire 1998 season. In 2000, he suffered a

rotator cuff injury, A-C joint sprains, and Axilla Nerve injury. He had surgery on the left shoulder in February of 2001, revealing multiple issues including impingement syndrome, bursitis, and anterior posterior labral tear.

Mr. Mickell has also suffered a series of injuries to his ankles, foot, elbow, chest, hand, and wrist. Mr. Mickell's recent MRIs of his cervical and lumbar spine, both knees, and hip show that these injuries are still affecting him. It would be interesting to see an MRI of his shoulders as well. The most interesting point of all of this is that the NFL denied Mr. Mickell's benefits not based on his physical condition but summarily on the grounds that he was working at the time of his application in September of 2013.

Below is a summary of the medical records which provide evidence of Mr. Mickell's conditions, including injuries, diagnosis, and treatment relevant to Mr. Mickell's P&T Disability claim. For your convenience, the following summary is organized by the part of the body affected. (A copy of the medical records summarized below were provided to the NFLPA via Federal Express overnight delivery on June 18, 2014 and another copy of the disc is included with this Appeal letter).[9]

SUMMARY OF MEDICAL RECORDS BY BODY PART

Knees

- August 19, 1991 – Bilateral Knee MRI (University of Florida)
  - MRI shows bilateral osteophytosis of femur at patella femoral joint with bilateral joint effusion and signal changes within the patellar cartilage and subchondral bone consistent with patellar chondromalacia.
- August 22, 1991 – Arthroscopy, Chondroplasty, and Patellofemoral Articulation of the Left Knee
  - Postoperative diagnosis of severe patellofemoral degenerative changes, Grade III and Grade IV.
  - The majority of both the facets of the patella and the trochlear area was covered with Grade III and Grade IV changes of chondromalacia.
- January 23, 1992 – MRI of Left Knee (University of Florida)
  - MRI shows that anterior horn of the medial meniscus is torn.
- February 14, 1992 – Left Knee Arthroscopy With Arthroscopic Plica Excision
  - Postoperative diagnosis of superomedial plica of the left knee and grade II/III chondromalacia of the patella.
  - Operation was performed as a result of meniscus tear diagnosis from MRI (1.23.92). There was no tear, but there was chondromalacia of the patella.
- August 26, 1992 – KC Chiefs Orthopedic Examination
  - Diagnosed with chondrolmalacia of the patella.
- October 4, 1992 – MRI of Left Knee

[9] A copy of the letter and CD are attached to this Appeal Letter as Exhibit "7".

- Showed small amount of fluid in the tibiofemoral joint, intermediate signal intensity within the posterior horn of the medial meniscus, and an osseous ridge projecting off the anterior margin of the medial femoral condyle, extending onto the medial trochlear facet.
- Diagnosed with moderate thinning of the articular cartilage of the median ridge of the patella and thickened medial shelf.

- October 14, 1992 – Training Room Exam
  - Still has the Patellofemoral Crepitus, graded at about 2+ primarily as the knee is brought from extension down into about 20-30 degrees of flexion.
  - Effusion measures 1 ¼ cm – greater on the left knee than that of the right knee.
- April 19, 1994 – KC Orthopedic Examination
  - Also diagnosed with bilateral chondromalacia patella.
- September 4, 1994 – KC Chiefs Injury Report
  - Suffered a MCL Knee sprain of the right knee when he was making a tackle on the ball carrier.
  - Also may have suffered a medial femoral condyle contusion.
  - Placed in a single bar brace splint immobilizer and had tenderness in his medial femoral epicondyle.
- February 13, 1995 – KC Chiefs Injury Report
  - Also continues to struggle with aching, tenderness, grinding and grating about both knees. There is persistent crepitus through the patellofemoral joint, and crepitus and grating through the lateral compartment of both knees. There is intermittent popping, catching and grinding. Indicates chronic synovitis with patellofemoral arthrosis that is noted to be Grade III perhaps even Grade IV.
- April 5, 1995 – KC Injury Report
  - Had arthroscopic surgery on both knees in March but still experiences some grating and grinding about both knees, more so with the left knee. There is still some very mild peripatellar crepitus, 1-2+ in the left knee.
- April 26, 1996 – New Orleans Saints Injury Report
  - Has a history of two knee arthroscopies on the right side, and three arthroscopies on the left.
- June 4, 1996 – Orthopaedic Exam
  - Also has pain in left knee and right little finger – dislocated finger in September of 1995 and there is a deformity in the finger since this time.
  - Left knee reveals slight varus – tender to palpation about the patellofemoral joint; has 2+ patellofemoral crepitus of both knees.
  - X-Rays of the left knee show some slight ridging of the articular surface, laterally, and some tilting of the patella, laterally.
  - Right knee shows some calcification off the medial femoral condyle consistent with an old Pellegrini-Stieda disease.

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- Has chondromalacia of the patella, worse in the left knee and early degenerative changes of a mild degree in the left knee.

- August 21, 1996 – Training room Visit, New Orleans Saints
  - Mild to moderate patellofemoral crepitus – suggested avoidance of squats.
- September 5, 1996 – Training room Visit, New Orleans Saints
  - Injury to right knee – was hit in the game
  - Exam shows little thickening of the knee, some pain or tightness with flexion.
  - Has a contusion with slight swelling.
- December 18, 1996 – Training room Visit, New Orleans Saints
  - Suffered hyperextension of his left knee resulting in strain of the patellar tendon.
- September 15, 1999 – Orthopaedic evaluation for New Orleans Saints
  - Suffers from chondromalacia patella, advanced in left knee, moderate in right knee.
  - Cleared to play football. Biggest concern would be the left knee.
- January 14, 2000 – San Diego Chargers Free Agent Physical
  - X-rays showed mild lateral patellar joint space narrowing and mild intercondylar osteophyte formation in both knees.
- October 15, 2000 – Left Knee Inflammation
- December 10, 2000 – Right Knee Medial Collateral Sprain
- July 29, 2011 – Oakland Raiders Injury Report
  - Complains of left knee pain from a probable contusion, chondromalacia, possible meniscal tear left knee.
- July 30, 2011 – Oakland Raiders Injury Report
  - Complains of left knee.
  - There is posteromedial joint tenderness with some pain with McMurray's.
  - Underlying degenerative joint disease and possible meniscal degeneration.
- April 5, 2014 – MRI of the Right Knee
  - Showed grade II strain of the distal biceps femoris muscle and tendon
  - Mild patellofemoral compartment osteoarthritic change. Early medial and lateral compartment osteoarthritic change is present as well.
  - Medial distal femoral metaphyseal 0.9 x 1.7 cm benign exostosis.
  - Medial meniscal postsurgical change without recurrent meniscal tear demonstrated.
  - Small right knee effusion
- April 5, 2014 – MRI of Left Knee
  - Mild patellofemoral compartment osteoarthritic change. Early medial and lateral compartment osteoarthritic change is present as well.
  - Anterior medial femoral condyle 1.2 x 1.4 cm chronic grade II osteochondral injury.

DG

- Small left knee effusion.
- 2.0 x 2.9 x 4.3 cm ganglion cyst within the posterior intercondylar region, along the posterior margin of the posterior cruciate ligament.

Hip

- September 7, 2000 – MRI of Right Hip
  - Been experiencing pain for five days.
  - There is a small effusion in the right hip joint and there may be low-grade chondromalacia affecting the posterior aspect of the joint.
- April 5, 2014 – MRI of Left Hip
  - Anterior left acetabular labral nondisplaced tear.
  - Mild – moderate bilateral hip osteoarthritic change, greater on the left.

Back/Neck

- August 26, 1992 – KC Chiefs Orthopedic Examination
  - Noted history of low back pain, but asserted that he would pass physical.
- January 3, 1994 – KC Chiefs Post-Game Injury
  - Suffered blow to low back area in game against Seattle Seahawks.
  - Day after there was swelling along the paraspinal muscle area adjacent to the SI joint and lumbosacral region of L5-S1 area.
  - Indicates a contusion in the lumbosacral paraspinal muscle and sprain of the right SI joint.
- October 30, 1994 – KC Chiefs Post-Game Injury
  - Suffered an injury to his right anterior sternocleidomastoid area in game against Buffalo Bills.
  - Indicated a contusion to anterior sternocleidomastoid resulting in soreness without swelling.
- August 19, 1995 – KC Post-Game Injury
  - Sustained injury to his posterior lateral neck region during Buffalo Bills game. Indicated acute posterior lateral cervical muscle strain causing discomfort to trapezius musculature.
- June 4, 1996 – Orthopaedic Exam
  - Developed back pain during the rookie camp and aggravated it during mini-camp. Complains of sharp pain in left low back radiating toward his left buttock.
  - Left lower lumbar area is tender to palpation.
  - Straight leg raise examination caused some low back pain bilaterally at about 70 degrees.
- June 26, 1996 – Physical Therapy Evaluation
  - Diagnosed with L4-L5 disc protrusion.
  - Demonstrates decreased
    - Postural awareness
    - Lumbar spine range of motion compared to AMA guidelines

DG

    - Pelvic/lower extremity flexibility
    - Trunk/pelvic strength
  - Specified tenderness along the right lumbar paraspinals and quadratus lumborum musculature.
- September 15, 1999 – Orthopaedic evaluation for New Orleans Saints
  - Has a history of recurrent lumbosacral strain – he probably has a degenerative lumbar disc.
- July 25, 2000 – Lumbar Erector Spinae Strain
- April 12, 2014 – MRI of Cervical Spine
  - C5-6 central disc herniation which impinges upon thecal sac, narrowing the central canal.
  - C6-7 central disc herniation which impinges upon thecal sac, narrowing the central canal.
  - Straightening of the normal cervical lordotic curve, possibly secondary to muscle spasm.
  - C2-3 and C3-4 early disc desiccation.
  - C4-5 early degenerative change with a small disc/osteophyte bulge.
- April 12, 2014 – MRI of Lumbar Spine
  - L4-5 central broad-based disc herniation which impinges upon the anterior thecal sac, narrowing the neural foramina bilaterally.
  - L5-S1 central broad-based disc herniation which impinges upon the anterior thecal sac, narrowing the neural foramina bilaterally. An associated annular tear is present.

Shoulders

- May 17, 1993 – KC Chiefs
  - X-rays of right shoulder showed a type II acromion and slight irregularity of his anterior humeral head.
  - This suggests possible shoulder subluxation and possible labral pathology of the right shoulder.
- July 23, 1993 – KC Chiefs Training Camp
  - Developed bilateral shoulder pain without history of a specific injury. Noted general soreness with any shoulder motion that was aggravated by football activities.
  - Pain was confined to pectoralis major and latissimus attachments on the humeral area suggestive of probable pectoralis major and possible latissimus strain.
- July 30, 1993 – KC Chiefs Injury Report
  - Suffered a rotator cuff strain in right shoulder when his arm was pulled down while being blocked by opposing player.
- July 30, 1993 – MRI of Right Shoulder

- MRI revealed tubular accumulation of fluid in the subscapular fossa interposed between the posterosuperior surface of the subscapularis muscle and the scapula. The fluid extends laterally and inferiorly.
- The appearance is compatible with either a ganglion cyst or fluid within the subscapularis recess containing multiple septations.
- There is also an irregularity of the inferior glenoid labrum.

- April 19, 1994 – KC Orthopedic Examination
  - Indicated mild axillary tenderness and mild pain in right shoulder.
- October 9, 1995 – KC Injury Report
  - Sustained injury to left shoulder with pain primarily deep within the axillar region initially resulting in tingling in his digits.
  - Soreness seemed to worsen and actively lacks about 15-20 degrees of forward flexion and 15 degrees of external rotation.
  - There is a reproduceable posterior apprehension sign both with posterior translation and the 90 degree abducted position and in the internal rotation adducted position.
  - Left shoulder radiographs suggest flattening of the anterior aspect of the humeral head possibly representing a reverse hill saks lesion. There is also a calcific fleck posterior to the glenoid that may represent a reverse bankhart lesion.
  - Suggests probable posterior subluxation episode left shoulder.
- October 11, 1995 – KC training room visit
  - Left shoulder MRI shows evidence of substantial acute injury with contusion of his posterior glenoid.
  - There is evidence of marked posterior capsular stripping – appears to be a type 3 anterior capsular attachment.
  - Left shoulder probable acute posterior subluxation, possible distal posterior dislocation and spontaneous reduction.
  - Placed shoulder in immobilizer in slight extension.
- October 11, 1995 – MRI Left Shoulder
  - Showed acute tear of the posterior joint capsule of the shoulder joint associated with fluid extending from the joint into the adjacent soft tissues dorsal to the neck of the scapula.
  - Also shows a tear of the posterior glenoid labrum and mild edema in the infraspinatus muscle.
  - Also shows an osseous contusion in the anteromedial margin of the humeral head.
- December 11, 1995 – KC Injury Report
  - Sustained a mild injury to his left shoulder during the game in Oakland in the week prior. Locally sore over the AC joint.
- April 26, 1996 – New Orleans Saints Injury Report

  - Also had a left shoulder AC separation – missed four games last year because of it.
- June 2, 1997 – Orthopaedic Visit
  - Injured right shoulder during last training camp and reinjured it when spring football practice started.
  - MRI indicated that there was evidence of multi-directional instability, impingement syndrome, and partial tear of rotator cuff.
- December 10, 1997 – Orthopaedic Visit
  - Injured right shoulder in a game.
  - Suggests strain to the rotator cuff of the right shoulder, also had a flare up of chondromalacia patella of the left knee.
- February 20, 1998 – Orthopaedic Visit
  - Suffered from questionable partial tear of the rotator cuff during 1997 season that bothered him all season and continues to bother him.
  - Has some pain in range of motion and shows slight weakness in rotator cuff strength, suggesting rotator cuff tendinitis with a possible partial tear.
- March 4, 1998 – Orthopaedic Visit
  - Evaluation of right shoulder shows evidence of bicipital tenosynovitis, possible SLAP lesion, with mild subacromial impingement.
  - Suggested plan was to have surgery on shoulder.
- September 15, 1999 – Orthopaedic evaluation for New Orleans Saints
  - Had right shoulder surgery in 1998.
- January 14, 2000 – San Diego Chargers Free Agent Physical
  - X-rays show calcification within the anterior acromion and AC joint in right shoulder. AC joint is narrowed.
- August 18, 2000 – Axilla Nerve Contusion
- August 25, 2000 – Left Clavicle A-C Sprain
- October 31, 2000 – MRI Left Shoulder
  - Anterior and superior pain for six weeks. Inability to lift weights, question of rotator cuff tear.
  - The changes within the acromioclavicular joint are consistent with an AC separation as we have discussed.
- November 14, 2000 – Left Clavicle A-C Sprain
- February 5, 2001 – Left Shoulder Surgery
  - Postoperative diagnoses of left shoulder impingement syndrome, left shoulder acromioclavicular joint arthrosis with osteolysis, and left shoulder anterior posterior labral tear.
  - Also shows marked bursitis, coracoacromial ligament hypertrophy and share anterior acromial spur.

Ankles

- January 2, 1994 – KC Chiefs Injury Report

  - Had another player fall on his ankle while he was blocked by a third player in a game against the Seattle Seahawks.
  - Resulted in a left ankle anterior talofibular ligament sprain.
- January 23, 1994 – KC Chiefs Post-Game Injury
  - Suffered inversion type injury to his left ankle in a game against Buffalo Bills.
  - Showed tenderness localized to the anterior lateral joint line of the fibulotailor ligament area and along the anterior deltoid ligament region.
- September 11, 1994 – KC Post-Game Injury
  - Suffered an eversion twisting injury to his right ankle in the San Francisco game, resulting in a sprain to his medial deltoid ligament of his right ankle.
- November 20, 1994 – KC Chiefs Injury Report
  - Suffered injury to his left ankle during game while rushing the passer when a player fell on his leg.
  - Suggested sprain of the distal fibulotailor ligament area.
  - X-ray showed OS changes along the lateral portion of the distal tibia suggestive of a possible old minor syndesmodic changes.
- September 17, 1995 – KC Injury Report
  - Sustained a right ankle sprain in game while attempting to avoid a block and another player rolled on his right ankle.
  - Most of his pain was in the anterior deltoid and over the anterior and posterior tib fib ligament.
  - Radiograph suggested very small possible capsular avulsion in the anterior aspect of the tibia.
- October 1, 1995 – KC Injury Report
  - Sustained a reinjury to his right ankle with soreness was still principally over the distal syndesmosis.
  - Suggests resolving syndesmotic ligament sprain.
- October 8, 2000 – Left Ankle Anterior Talo-Fib Sprain

Other Injuries

- August 26, 1992 – KC Chiefs Orthopedic Examination
  - Exam noted a history of multiple joint spasms in the hand and limited range of motion in middle finger and thumb.
- December 26, 1993 – KC Chiefs Post-Game Injury
  - Suffered a forced dorsiflexion injury to his mid foot.
  - Suggested probable sprain of the intermetatarsal ligament.
- April 19, 1994 – KC Orthopedic Examination
  - Noted multiple joint sprain and residual problems in the fingers, as well as injuries to Spine, ankle and foot.
- October 9, 1994 – KC Chiefs Injury Report

- Suffered an injury to his right ribs while trying to avoid a block.
- Suffered right rib coastal chondral/cartilage separation.

- October 10, 1994 – KC Chiefs Post-Game Injury
  - Suffered an injury to the chest wall in practice during the week of 10/3/94.
  - Showed a little bit of swelling through the T10 through T12 area.
- November 13, 1994 – KC Chiefs Injury Report
  - Suffered a left lateral elbow contusion while being blocked by opposing team player in game against San Diego.
  - Indicated distal triceps tendinitis and lateral epicondylar contusion.
- December 4, 1994 – KC Chiefs Injury Report
  - Suffered dislocation of the PIP joint of left long finger with a small avulsion fracture at the base when his hand struck the leg of an opposing player.
- December 14, 1994 – KC Chiefs Training Room Visit
  - Seen for his left long finger and left ankle injuries.
  - Also reported injury to right wrist that first occurred in the week prior and was reinjured the Monday before (both during games).
  - Had right wrist placed in an extension block splint during practices and games.
- February 13, 1995 – KC Chiefs Injury Report
  - Seen for injury to right wrist suffered during season as well as bilateral knee pain.
  - The pain in the right wrist is localized to the distal radial ulnar joint subject to intermittent catching, popping and discomfort, suggesting possible triangle fibrocartilage tear of right wrist.
- April 25, 1995 – Orthopedic Examination
  - Noted history of injury to both shoulders, left elbow, left long finger, bilateral thumbs, left hand, right side of spine/ribcage, both knees and both feet.
- September 10, 1995 – KC Post-Game Injury
  - Complains of discomfort in the area of the left 12th rib that was aggravated in New York Giants game. Indicates left external oblique strain at costal origin.
- June 4, 1996 – Orthopaedic Exam
  - Right little finger reveals a 40 degree flexion contracture and can only flex it to about 80 degrees.
  - X-Rays of the right little finger shows calcification on the distal portion of the proximal phalanx.
- September 23, 1996 – Training room Visit, New Orleans Saints
  - Got hit on the left anterior hip, also got hit on the right elbow.
  - Also complains of pain in right big toe.
  - X-ray on toe show a small dorsal spur on the proximal phalanx.
- November 18, 1996 – Training room Visit, New Orleans Saints

- Injury to right elbow and hand.
- Shows pain when stressing the elbow, some pain with full extension and flexion.

- November 27, 1996 – Training room Visit, New Orleans Saints
  - Suffered sprain to the midfoot-forefoot area laterally.
- January 14, 2000 – San Diego Chargers Free Agent Physical
  - There is mild residual Boutonniere deformity of his right little finger.
  - Has an acute right ankle sprain that caused him to fail physical.
- August 5, 2000 – Left Elbow Ulnar Nerve Contusion

- January 9, 2014 – Ralph Miniet, M.D., The Angel's Medical Services – severe pain in arms with numbness and loss of strength through both arms. Assessment: Central disc. Herniation, C6 – 7; Disc Buldge C4-5 and C5-6. Dr. Miniet prescribed Valium 10mg, 1 tab at bedtime; Oxy Codone 30mg, 2 tab, TID, and —-350 mg, 1 tab at bedtime.

FUNCTIONAL CAPACITY EXAMINATION

In addition to the foregoing medical documentation, the undersigned provided the NFLPA a copy of **the independent medical examination report from Craig Lichtblau, M.D.** Mr. Mickell underwent an IME by Dr. Lichtblau on March 31, 2014. According to Dr. Lichtblau's report:

Review of Systems:

CONSTITUTIONAL: Weight gain, weakness, fatigue, and difficulty sleeping. SKIN: The patient denies rashes, pruritus, or lesions. HEAD: Headaches and dizziness. EYES: The patient denies change in visual fields, photophobia, diplopia, inflammation, discharge, or glasses. EARS, NOSE, MOUTH, AND THROAT: EARS: The patient denies hearing changes, tinnitus, pain, or discharge. NOSE: The patient denies sinus problems, nose bleeds, or obstructive polyps. THROAT: The patient denies inflammation, lesions, discharge, or hoarseness. MOUTH: The patient denies dentures, lesions, or discharge. RESPIRATORY: The patient denies shortness of breath, wheezing, cough, or hemoptysis. CARDIOVASCULAR: The patient denies hypertension, chest pain, dyspnea, rheumatic fever, murmurs, orthopnea, cyanosis, edema, claudication, or palpitations. GASTROINTESTINAL: The patient denies decreased appetite, dysphagia, nausea, vomiting, hematemesis, indigestion, pain, diarrhea, constipation, melena, or hemorrhoids. GENITOURINARY: Increased urination, sexual dysfunction, and thyroid problems. ENDOCRINE: The patient denies polyphagia, polydipsia, polyuria, thyroid problems, glycosuria, or hormone therapy. MUSCULOSKELETAL: Joint pain, stiffness, and muscle pain. HEMATOLOGY: The patient denies anemia, bleeding tendency, easy

bruising, or lymphadenopathy. NEUROPSYCHIATRIC: Coordination problems, memory changes, dizziness, and emotional disturbance.

Physical Examination:

Constitutional: General: Well-nourished, well-developed male. Vital Signs: Stable, afebrile. BP is 120/70. Heart rate is 46. 02, saturation is 99%.

Psychiatric: Alert and oriented x 3. The patient is in no acute distress. The patient was able to recall 2 out of 3 objects, instant recall, and 0 out of 3 objects in five minutes. The patient had difficulty and had to stop because he had wrong answers performing serial subtractions of 7 starting with a 100.

Skin: Without scars, masses, lesions, or discharge.

Head: Atraumatic, normocephalic.

Eyes: Pupils are equal, round and reactive to light and accommodation. Extraocular movements full. Sclera clear. Ophthalmic examination deferred.

Ears/Nose Mouth & Throat: Ears without discharge. Nose without obstruction. Without lesions or masses. Otoscopic examination deferred. Hearing within functional limits. The patient was able to identify 1 out of 3 smells using a pocket smell test.

Neck: Without carotid bruits. Neck supple. No masses.

Respiratory: Auscultation of lungs without adventitious breath sounds. Respiration without use of accessory muscles.

Cardiovascular: Heart: Auscultation of heart reveals S1 and S2. No gallops, murmurs, or heaves. Regular rate and rhythm. Pulses: Radial pulse and dorsal pedal pulse 2+ bilaterally.

Gastrointestinal: Bowel sounds present in all four quadrants. Without rebound tenderness. Without masses.

Musculoskeletal: AROM within functional limits for all joints. Extremities: The patient has tenderness to light palpation along his cervical and lumbar paraspinal muscles with palpable spasm in his cervical and lumbar paraspinal muscles and across his trapezius muscles and quadratus lumborum muscles bilaterally. The patient has tenderness to light palpation in the medial and lateral joint lines of both knees. The patient has palpable crepitus with flexion and extension in both knees. The patient has tenderness to light palpation generalized over his shoulders with more exquisite tenderness at his left anterior deltoid region. Gait: The patient ambulates with a normal gait, unassisted.

Neurological: Speech normal. Cranial Nerves: II through XII intact. Deep Tendon Reflexes: 1+/4 throughout. Sensory: Intact to light touch, pinprick, position, and cold sense throughout. Motor: 5/5 throughout.

Diagnostic Impression:

1. Cervical and lumbar myofascial pain, secondary to multiple injuries sustained while playing for the National Football League from 1992 to 2001.

2. History of chronic headaches, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

3. Probable traumatic brain injuries with subsequent chronic posttraumatic headaches and cognitive deficits, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.

4. Bilateral shoulder myofascial pain, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.

5. History of bilateral knee myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

6. Left hip myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

7. History of bilateral joint effusions and signal changes within his patella cartilage and subchondral bone, consistent with patella chondromalacia, indicated on bilateral knee MRIs obtained on 08/19/91, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

8. Status post examination of his left knee under anesthesia with diagnostic arthroscopy, chondroplasty, and patellofemoral articulation, performed on 08/22/91 by Dr. Peter Indelicato, secondary to patellofemoral pain syndrome with probable severe degenerative changes of his patellofemoral articulation with recurrent effusions, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

9. History of anterior horn medial meniscus tear, indicated on MRI of his left knee obtained on 01/23/92, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

10. Status post left knee arthroscopy with arthroscopic plica excision, performed by Dr. Peter Indelicato and Dr. Richard Vlasak on 02/14/92, secondary to grade II/III chondromalacia of his patella with superomedial plica of his left knee, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

11. History of moderate thinning of his articular cartilage of the median ridge of his patella, indicated on MRI of his left knee obtained on 10/05/92, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

12. History of pectoralis major and possible latissimus dorsi strain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

13. History of tubular accumulation of fluid in his subscapular fossa interposed between the posterior-superior surface of the subscapularis muscle and the scapula with multiple septations within the fluid with irregularity of his inferior glenoid labrum, indicated on MRI of his right shoulder obtained on 07/30/93, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

14. History of a sprain to the anterior talofibular ligament of his left ankle, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

15. History of contusion with lumbosacral paraspinal muscle sprain of his right sacroiliac joint, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

16. History of an acute tear of his posterior joint capsule of his left shoulder joint associated with fluid extending from his joint into his adjacent soft tissue dorsal to the neck of his scapula with a tear of the posterior glenoid labrum with mild edema, posterior subluxation/dislocation of his humeral head with a large joint effusion identified within his glenohumeral joint, indicated on MRI of his left shoulder obtained on 10/11/95, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

17. History of a small effusion at his right hip joint with low grade chondromalacia affecting the posterior aspect of his joint, indicated on MRI of his right hip obtained on 09/08/00, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

18. History of changes at his acromioclavicular joint, consistent with an acromioclavicular separation, indicated on MRI of his left shoulder obtained on 10/31/00, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

19. Status post right shoulder arthroscopy, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

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20. Status post left shoulder arthroscopy, arthroscopic subacromial decompression with coracoacromial ligament resection, arthroscropic distal clavicale excision through anterior portal, anterior-posterior labral debridement, and anterior-superior labral repair, performed on 02/05/01 by Dr. David Chao, Dr. Paul Murphy, and Dr. Calvin Wong, secondary to his left shoulder impingement syndrome and left shoulder acromioclavicular joint arthrosis with osteolysis, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

21. History of a central disk herniation at his C6-C7 spinal level with bulging disks at his C4-C5 and C5-C6 spinal levels and straightening of his normal cervical lordosis, indicated on MRI of his cervical spine without contrast completed on 06/07/11, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

22. History of a distal biceps femoris muscle and tendon grade II strain with mild patellofemoral compartment osteoarthritic change, early and medial lateral compartment osteoarthritic change, with medial meniscal postsurgical change without recurrent meniscal tear, and a small right knee effusion, indicated on MRI of his right knee without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

23. History of mild patellofemoral compartment osteoarthritic change, early and medial lateral compartment osteoarthritic change; small left knee effusion, 2.0 x 2.9 x 4.3 cm ganglion cyst within the posterior intercondylar region along the posterior margin of his posterior cruciate ligament; and a chronic grade II osteochondral injury in his anterior medial femoral condyle, indicated on MRI of his left knee without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

24. History of anterior left acetabular labral nondisplaced tear with moderate bilateral hip osteoarthritic change, greater on the left, indicated on MRI of his left hip/pelvis without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

25. Acute functional decline secondary to chronic pain, depression, erectile dysfunction, secondary to numbers 1 through 24, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

Assessment:

This is a pleasant 43-year-old, right-hand-dominant African-American male, who played defensive end for the National Football League from 1992 to 2001. The patient played on several different teams, including Kansas City, New Orleans, San Diego and Oakland. Throughout his years playing football in the National Football League, the patient sustained multiple serious injuries numerous times, including

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injuries to his head, neck, lower back, shoulders, knees, and hips. The patient's chronic pain eventually caught up with him, and he had to retire from the National Football League in 2001.

Following retirement, the patient continued to have a significant amount of pain and cognitive dysfunction, which got progressively worse over time. The patient states at one point he attempted to find employment because of his financial situation, but could not perform the job duties required after about a year and a half, secondary to his functional decline.

Plan:

Today, I have recommended the patient for follow-up MRIs of both knees and his left hip.

An MRI of his right knee completed on April 5, 2014 demonstrated a distal biceps femoris muscle and tendon grade II strain with a component of early fatty atrophy, mild patellofemoral compartment osteoarthritic changes with medial and lateral osteoarthritic changes, benign exostosis, medial distal femoral metaphyseal, and medial meniscal post-surgical changes with small right knee effusion.

An MRI of his left knee completed on April 5, 2014 demonstrated mild patellofemoral compartment osteoarthritic changes, anterior medial femoral condyle chronic grade II osteochondral injuries, small left knee effusion, and a ganglion cyst within his posterior intercondylar region and along the posterior margin of his posterior cruciate ligament.

An MRI of his left hip obtained on April 5, 2014 demonstrated an anterior left acetabular labral non-displaced tear and mild-to-moderate bilateral hip osteoarthritic changes, greater on the left.

After obtaining the history, performing a physical examination, and reviewing voluminous medical records, it is my medical opinion as a Board Certified Physiatrist that this patient's chronic pain, decreased functional ability, and cognitive deficits are a direct result of injuries sustained while playing for the National Football League from 1992 to 2001.

It is my medical opinion as a Board Certified Physiatrist that this patient has sustained a significant impairment and disability.

In order to accurately define this patient's impairment and disability, the following will be performed:

1. Medical Functional Capacity Assessment.

2. AMA Impairment Rating.

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3. Functional Assessment.

4. Summary Report.

5. Photographs.

Dr. Lichtblau's' Medical Functional Capacity Assessment Provides:

Diagnoses:

1. Cervical and lumbar myofascial pain, secondary to multiple injuries sustained while playing for the National Football League from 1992 to 2001.

2. History of chronic headaches, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

3. Probable traumatic brain injuries with subsequent chronic posttraumatic headaches and cognitive deficits, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.

4. Bilateral shoulder myofascial pain, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.

5. History of bilateral knee myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

6. Left hip myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

7. History of bilateral joint effusions and signal changes within his patella cartilage and subchondral bone, consistent with patella chondromalacia, indicated on bilateral knee MRIs obtained on 08/19/91, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

8. Status post examination of his left knee under anesthesia with diagnostic arthroscopy, chondroplasty, and patellofemoral articulation, performed on 08/22/91 by Dr. Peter Indelicato, secondary to patellofemoral pain syndrome with probable severe degenerative changes of his patellofemoral articulation with recurrent effusions, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

9. History of anterior horn medial meniscus tear, indicated on MRI of his left knee obtained on 01/23/92, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

10. Status post left knee arthroscopy with arthroscopic plica excision, performed by Dr. Peter Indelicato and Dr. Richard Viasak on 02/14/92, secondary to grade II/III

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chondromalacia of his patella with superomedial plica of his left knee, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

11. History of moderate thinning of his articular cartilage of the median ridge of his patella, indicated on MRI of his left knee obtained on 10/05/92, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

12. History of pectoral's major and possible latissimus dorsi strain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

13. History of tubular accumulation of fluid in his subscapular fossa interposed between the posterior-superior surface of the subscapularis muscle and the scapula with multiple septations within the fluid with irregularity of his inferior glenoid labrum, indicated on MRI of his right shoulder obtained on 07/30/93, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

14. History of a sprain to the anterior talofibular ligament of his left ankle, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

15. History of contusion with lumbosacral paraspinal muscle sprain of his right sacroiliac joint, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

16. History of an acute tear of his posterior joint capsule of his left shoulder joint associated with fluid extending from his joint into his adjacent soft tissue dorsal to the neck of his scapula with a tear of the posterior glenoid labrum with mild edema, posterior subluxation/dislocation of his humeral head with a large joint effusion identified within his glenohumeral joint, indicated on MRI of his left shoulder obtained on 10/11/95, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

17. History of a small effusion at his right hip joint with low grade chondromalacia affecting the posterior aspect of his joint, indicated on MRI of his right hip obtained on 09/08/00, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

18. History of changes at his acromioclavicular joint, consistent with an acromioclavicular separation, indicated on MRI of his left shoulder obtained on 10/31/00, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

19. Status post right shoulder arthroscopy, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

20. Status post left shoulder arthroscopy, arthroscopic subacromial decompression with coracoacromial ligament resection, arthroscropic distal clavicale excision through anterior portal, anterior-posterior labral debridement, and anterior-superior labral repair, performed on 02/05/01 by Dr. David Chao, Dr. Paul Murphy, and Dr. Calvin Wong, secondary to his left shoulder impingement syndrome and left shoulder acromioclavicular joint arthrosis with osteolysis, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

21. History of a central disk herniation at his C6-C7 spinal level with bulging disks at his C4-C5 and C5-C6 spinal levels and straightening of his normal cervical lordosis, indicated on MRI of his cervical spine without contrast completed on 06/07/11, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

22. History of a distal biceps femoris muscle and tendon grade II strain with mild patellofemoral compartment osteoarthritic change, early and medial lateral compartment osteoarthritic change, with medial meniscal postsurgical change without recurrent meniscal tear, and a small right knee effusion, indicated on MRI of his right knee without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for, the National Football League from 1992 to 2001.

23. History of mild patellofemoral compartment osteoarthritic change, early and medial lateral compartment osteoarthritic change; small left knee effusion, 2.0 x 2.9 x 4.3 cm ganglion cyst within the posterior intercondylar region along the posterior margin of his posterior cruciate ligament; and a chronic grade II osteochondral injury in his anterior medial femoral condyle, indicated on MR1 of his left knee without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

24. History of anterior left acetabular labral nondisplaced tear with moderate bilateral hip osteoarthritic change, greater on the left, indicated on MRI of his left hip/pelvis without contrast obtained on 04/05/14, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

25. Acute functional decline secondary to chronic pain, depression, erectile dysfunction, secondary to numbers 1 through 24, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

Occupation:

The patient is currently unemployed. He was last employed as a professional football player for the National Football League from 1992 to 2001.

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Functional Activities:

Prior to performing the functional portion of the assessment, the patient was instructed in proper body mechanics and posture. He was informed that he had the right to terminate any activity or the test in its entirety, if his pain and/or symptoms increased. He understood that if he completed the Medical Functional Capacity Assessment, it was of his own volition.

1. Lift Activities:

A. The patient performed a 2-handed basket lift from the floor-to-waist height with 30 lbs. for a total of lx. The patient stopped the activity due to bilateral knee pain, low back pain, left hip pain, and had difficulty getting this low.

B. The patient performed the 2-handed basket lift from a stool 12" off the floor-to-waist height with 30 lbs. 8x. The patient stopped the activity due to left knee, left hip, and low back pain.

C. The patient performed a 2-handed basket lift from a table at waist height to shoulder height with 30 lbs. 5x. The patient stopped the activity due to bilateral shoulder fatigue.

D. The patient performed a 2-handed basket lift from a table at waist height to overhead position with 20 lbs. 7x. The patient stopped the activity due to bilateral shoulder burning fatigue.

E. The patient performed a 2-handed basket lift from a stool 12" off the floor and carried 30 lbs. 60 feet for 2 repetitions. The same lift was performed with the right hand using 30 lbs. for 60 feet, and the left hand using 30 lbs. for 60 feet. The patient stopped the activity due to:

2-hand carry: Increased left shoulder and low back pain.

Right-hand carry: A little shoulder fatigue and a little increased low back pain.

Left-hand carry: Left shoulder fatigue and a little increased low back pain.

2. Reaching Activities:

The patient performed a one-hand diagonal reach and lift from the waist-to-shoulder height using plastic light-weight cones. The test was performed with the right wrist weighted with 5 lbs. 22x for 56 seconds and the left wrist was weighted with 5 lbs. 15x for 40 seconds. The patient stopped the activity with the right and left due to shoulder pain and fatigue.

3. Upper Extremity Tests:

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Various fine motor activities were performed:

A. The patient manipulated one washer from a stack to a peg using the thumb and alternating fingers, right hand 4 washers, left hand 4 washers. The patient performed within normal limits bilaterally; however, with the right, the second finger dropped one.

B. The patient manipulated a clothes pin using the thumb and alternating fingers to squeeze the clothes pin and pick up a single bean. Right hand 4 beans, left hand 4 beans. The patient performed within normal limits bilaterally; however, he complained of getting a headache.

4. Endurance Arm Test:

The patient performed this activity with weighted and un-weighted wrists. The patient's upper extremity was positioned at .12" above his shoulder height. The patient was instructed to place both hands on light-weight plastic cones moving them from the left to the right in a repetitive motion. This was performed with the right wrist weighted at 5 lbs. and the left wrist at 5 lbs., for a total of 13x in 36 seconds. The second portion of the test was performed with un-weighted wrists for a total of 25x in 51 seconds. The patient stopped the weighted activity due to increased low back pain and some fatigue. The patient stopped the un-weighted activity due to bilateral shoulder pain, right greater than left, and some increased low back discomfort.

5. Hand Dynamometer Strength Test:

The patients arm was placed by his side with the elbow at 90 degrees and he was instructed to squeeze the hand dynamometer. The right hand presents with 86 lbs. (39 kg) and the left with 88 lbs. (40 kg). The patient is right hand dominant. Hand dynamometer grip level: #4. The patient had no complaints with the right hand; however, on the left, he complained of the gripper hurting his palm.

6. Hand Sensation:

Intermittent tingling in his fingertips bilaterally.

7. Repetitive Activities:

A. Repetitive bending was performed 10x. The patient stopped the activity due to increased low back pain.

B. Repetitive kneeling was not performed due to the patient's inability to safely assume and maintain the position.

8. Ladder Climb Test:

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The ladder climb test was performed on the Precor Stairmaster. He performed 10 steps in 24 seconds. The patient stopped the activity due to bilateral knee pain, left greater than right.

9. Treadmill Test:

This test was performed on the Biodex Treadmill. The patient ambulated 0.14 miles at 1.8 mph in 5 minutes, 10 seconds with 0% incline. The patient stopped the activity due to increasing pain in his low back, left hip, and left knee.

10. Isometric Testing:

This portion of the assessment was performed on the Biodex Lift Simulator. This test required the patient to perform four separate lifts. In each lift position, the patient was required to perform three separate contractions, each lasting six seconds in duration, with a five second rest between each contraction.

A. Position #1 — Floor Lift:

The patient was unable to perform the floor-to-knees lift due to his inability to safely assume and maintain the position.

B. Position #2 — Knee Lift:

The patient was unable to perform the knees-to-hips lift due to his inability to safely assume and maintain the position.

C. Position #3 — Hip Lift

Maximum average force of 109.0 lbs. Work fatigue 8.37%. The patient's output was consistent and he was able to maintain tension throughout the 6-second duration. The patient complained of increased lower back pain with sharp, shooting pain to his left shoulder.

D. Position #4 — Overhead Lift:

Maximum average force of 59 lbs. Work fatigue -2.02%. The patient's output was consistent and he was able to maintain tension throughout the 6-second duration. The patient complained of bilateral shoulder pain, right greater than left, and lower back discomfort.

11. Activities Not Performed:

- 7B
- 10A,B

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12. Clinical Observations:

The patient was cooperative and followed instructions throughout the Medical Functional Capacity Assessment. He demonstrated good body mechanics and material handling ability. He paced himself properly between activities. He did not require frequent rest periods but did require some changes in position. There was a close correlation between the patient's complaints of pain, general weakness, general decreased endurance, extremity weakness, and his functional ability.

It is my belief that this patient does not have the functional capacity to work 4 hours per day on an uninterrupted basis at this time. He should be in a job setting which allows him to take breaks to change positions from sit-to-stand/stand-to-sit frequently at will for positional comfort. He may sit, stand, and walk as tolerated. He may perform limited bending, limited reaching overhead, limited pushing and pulling. He should avoid kneeling, squatting, climbing unprotected heights, running, and jumping. His estimated physical demand characteristics from the hips-to-overhead position should remain at the light level, which is specifically defined by the Dictionary of Occupational Titles as lifting 20 lbs. infrequently and 10 lbs. or less frequently. This patient should always observe appropriate body mechanics which includes, but is not limited to, never bending at his waist while keeping his hips and knees extended.

It should be understood this patient is going to suffer from acute, intermittent exacerbations of chronic pain and discomfort and, when he experiences these acute, intermittent exacerbations of pain and discomfort, he will have good days, bad days, and missed days of work.

It is my medical opinion, as a Board Certified Physiatrist, this patient will be unable to maintain gainful employment in the competitive open labor market or in a sheltered environment with a benevolent employer, secondary to acute, intermittent exacerbations of chronic pain.

Dr. Lichtblau's' Functional Assessment Provides:

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secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

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After obtaining a history and performing a physical examination, as well as observing this patient participate in a Medical Functional Capacity Assessment, it is my medical opinion as a Board Certified Physiatrist that as this patient suffers the secondary effects of aging, combined with his current impairment, his disability will actually increase over time.

NEUROPSYCHOLOGICAL EVALUATION

Mr. Mickell also underwent Neuropsychological Evaluation by Mark Todd, Ph. D. According to the Neuropsychological Evaluation of Mark E. Todd, Ph.D. on April 8, 14th, and 21st, 2014:

HISTORY OF DIFFICULTIES:

The patient notes that he has been experiencing slow progressive memory changes over the last few years. He tends to forget recent and to some extent remote memories. He has trouble with numbers. He may have trouble with direction when driving. He forgets tasks that he intended to do. He may forget appointments.

He reports that his family is concerned about his difficulties. In fact, he noted that they were really the one that brought his difficulties to his attention, so he has now become increasingly aware. His girlfriend noted that he is clearly forgetful.

He reports word finding and word expressive difficulties. He notes problems with language comprehension. His handwriting is less neat. He notes that he can be easily distracted. He has problems with concentration.

His other chief problem is with irritability. He can be more emotional overall and otherwise can be sad and easily angered. His girlfriend noted that his personality is quite different. He admits to significant symptoms of anxiety and depression. He admits that he has at times been suicidal.

He has lost significant weight. He was sleeping more, but now sleeps only 4 hours a day having problems with sleep onset as well as mid sleep awakening. He has been depressed for at least 3 years now. He notes diminished libido. He has become less social. He has given up activities that used to be enjoyable. He is more irritable and confrontational.

He has frequent headaches as often as 3 times a week. He characterizes this as a left-sided constant pain, almost like a pressure. He notes numbness and tingling in his toes and fingers.

He has pain in his neck. He has bilateral knee and shoulder pain. He has pain in his back as well as in his left hip and to his groin. He has trouble obtaining relief for his pain.

BEHAVIORAL OBSERVATIONS:

The patient was noted to be pleasant and cooperative. He became notably upset on several occasions, especially when confronted with cognitive problems. This is obviously distressing to him.

He appeared to put forth his best effort. Speech was normal, coherent, and largely goal-directed. He could be distracted, but was easily redirected.

Station and gait are adequate. Response latencies are adequate. Attentional skills are fair.

His affect was somewhat constricted. His mood seemed depressed and worried. He demonstrated at least marginally adequate insight and judgment. Overall, the results of this examination appear to reflect a relatively accurate indication of functioning.

PERSONALITY EVALUATION:

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On the validity scales, there was a slight elevation on F suggestive of perhaps some slight confusion in responding. Nonetheless, a valid profile was believed to have been obtained.

There were marked elevations on most of the clinical scales including 1, 2, 3, 4, 7 and 8 as well as a milder elevation on 9. This is indicative of an individual experiencing marked anxiety and depression with some agitation and perhaps irritability. He is noting great physical and somatic complaints and measurable concern about his difficulties. He may be feeling somewhat socially alienated or confused.

The MMPI results are actually consistent with his clinical presentation and reported behavior at home and indicates an individual experiencing a marked mood disorder. He is quite concerned about the difficulties that he is facing and the significance of his perceived cognitive changes. He is worried about his ability to provide for his family, but also to take care of himself.

In addition, he also has significant physical and somatic complaints related to the multiple orthopedic injuries he sustained while playing professional football. He does not appear to be somatically preoccupied or hypochondriacal. His complaints had a basis in fact related to his known history.

INTELLECTUAL FUNCTIONING:

The patient's general intellectual functioning as measured by the WAIS-IV appeared to be low average. He demonstrated average perceptual reasoning and working memory whereas he had low average verbal comprehension. His processing speed index was only borderline and a relative weakness for him.

The patient's age-corrected subtest scaled scores are presented below.

WAIS -IV

Full Scale IQ = 87

VCI = 89 PRI=94

WMI =97 PSI = 79

It also involves capacity for understanding concrete and abstract concepts. Based on his age-corrected scaled scores, he demonstrated average to low average expressive vocabulary, verbal abstract reasoning and fund of information.

Visual constructional ability using blocks as well as nonverbal problem solving and reasoning appeared to be in the average to low end of average range.

His immediate recall of digits is low end of average. His ability to perform mental arithmetic problems is average.

The subtests in the processing speed section of the WAIS-IV involve assessment of fine motor coordination, psychomotor speed and speed of visual scanning, His performance on both tasks were in the low average range.

Academic skills were screened using the WRAT-IV. Reading recognition appeared low average (standard score of 83) where as written arithmetic was low end of average (standard score of 90).

LANGUAGE SKILLS:

Cognitive production as measured by verbal fluency is low end of average as he generated 30 words over 3 one-minute trials (standard score of 90). His ability to identify words fitting into a category is high average, as he generated 23 words over 3 one-minute trials (standard score of 115). On a task requiring him to name line drawings to confrontation, he obtained a score of only 46, which may be somewhat less than expected.

EXECUTIVE FUNCTIONING:

The patient's speed of reading color names appeared to be borderline (standard score of 79). Speed of identification of colors was low average (standard score of 89). Speed of identification of colors in the face of interfering verbal stimuli appeared average (standard score of 104).

Nonverbal executive functioning was assessed using the Trail Making Test. On Part A, which requires sequencing of numerals, the patient's performance is low average (standard score of 80). On Part 13, which requires alternation between numbers and letters, the patient's performance is low average (standard score of 85).

On a measure of sustained vigilance, the patient's performance was in the average range for speed (T-score of 45) as well as accuracy (T-score of 48).

VISUAL PERCEPTUAL SKILLS:

The patient's ability to reproduce copy of a complex visual design is average (standard score of 95). However, on a task requiring him to perceptually reorganize objects, which have been cut up and rearranged his performance, was only 21 out of 30, which is clearly less than expected.

LEARNING AND MEMORY:

Three subtests of the Wechsler Memory Scale-IV involving verbal or visual learning and short-term memory were administered. The patient had a score of 20 in his immediate

recall of several stories after hearing them, which is low average performance (standard score of 90). Short-term recall for the stories 30 minutes later is a 19, which is low end of average (standard score of 95).

On a 2nd rote learning word paired associates task, the patient's performance was discontinued after 2 trial scores of 1. He seemed especially frustrated on this task, which is why this measure was stopped. This would seem to be less than expected performance.

On a 3rd task involving the visual reproduction of designs from memory immediately after studying them, the patient obtained a score of 34, which is law end of average (standard score of 90).

Short-term recall for the designs 30 minutes later is a 14, which is low average performance (standard score of 80) and clearly reflects loss of information over the delay.

Visual memory abilities were also assessed using a forced choice recognition learning and memory task for novel visual designs. The patient's initial learning was actually quite good (91st percentile). However, short-term recognition memory for the designs 30 minutes later was only borderline (standard score of 4th percentile), clearly reflecting marked loss of information over the delay. These scores are noted despite adequate visual discrimination as he correctly identified 7 out of 7 in a forced choice discrimination format.

His motivation to perform at his best was assessed using a 21-Item List learning task. His performance on the forced choice measure and free recall measures were well within normal limits (forced choice = 18/21) and (free recall = 7/21). This finding is consistent with the rest of his test behavior and indicates that he appeared to put forth his best effort. A valid measure of functioning was believed to have been obtained.

SUMMARY OF FINDINGS:

Darren Mickell' is a 43-year-old right-handed black male who is a retired NFL defensive end. He sustained multiple orthopedic injuries as a result of his play. He also believes that he may have sustained concussive type injuries. While he was never formally diagnosed with concussion, he noted that there were several times where he hit his head and missed plays because of his cognitive problems.

Within this context, he is concerned that he is exhibiting evidence of slow progressive cognitive decline. He notes memory difficulties, expressive and receptive language problems, inattentiveness and problems with concentration. It is harder for him to read. His handwriting is less neat.

Within this context, he also notes behavioral difficulties with notable depression. He can be irritable. His behavior can be quite different from the way it was before with some irritability.

He also has significant pain in multiple areas. He complains of problems with headache. His sleep is now strained.

Within this context, he has had multiple orthopedic procedures because of his injuries. He tends to minimize a significant family history.

A review of records indicate that he sustained multiple orthopedic injuries playing football. As best as can be determined, he had initial treatments in college, which continued into his pro career. He was somewhat forced to retirement in 2001 because of his physical problems. He notes that subsequent to that event he has had difficulty with work. He attempted to return to work in 2012, but eventually had to stop work because of his physical problems and cognitive difficulties.

The patient notes that he has had increasing depression over the last 3 years. He denies a family psychiatric history.

Assessment of mood functioning with the MMPI-IRF revealed evidence of marked mood symptoms with depression, anxiety, and worry. He is also admittedly fearful about his future.

Neuropsychological testing together with educational, employment, and life history indicates an individual of overall premorbid mental abilities in the average to low average range. He continues to demonstrate average to low average reading recognition, written arithmetic, verbal abstract reasoning, expressive vocabulary, fund of information, attention and concentration, visual discrimination, visual constructional ability, nonverbal reasoning, letter fluency, and categorical fluency. Naming might be slightly low.

On the other hand, tests of processing speed clearly reveal some slowing, as the scores are low average to borderline. Verbal executive functioning is average. Nonverbal executive functioning is low average. Sustained attention is average.

While visual construction ability is average, visual organizational ability is clearly less than expected. With regard to memory skills, new learning and short-term memory of semantic discourse is average; however, rote verbal learning seems less than expected. Visual learning is average. His short-term memory is low average. On another rote visual learning task, his performance is clearly above average, but short-term memory is only borderline.

Testing indicated evidence of good motivation.

IMPRESSION:

Overall, the patient's neuropsychological profile appears to provide evidence of a mild cognitive disorder. He clearly has less than expected memory for visual information as well as problems with rote verbal learning. He may have some slightly less than expected cognitive efficiency with mild slowing and perhaps some mild difficulties with visual perceptual analysis.

The etiology of his impairment is less clear. Certainly, his mood symptoms are a prominent problem that could contribute to and may even account for his difficulties. The concern would be, however, that his problems may also be more reflective of a significant cognitive disorder related to a potential history of multiple concussive injuries. Certainly, given his history of ongoing depression with some behavioral dyscontrol as well as cognitive complaints, there are concerns that his current difficulties may represent a more significant issue.

RECOMMENDATIONS:

The patient was referred to the Players' Trust Program. He needs to follow up with medical care for his multiple difficulties,

Toward this end, he needs to be treated regularly for his pain. It is uncertain whether a pain management program can be established. It is uncertain as well whether he would benefit from orthopedic treatments.

Certainly, adopting a fitness program might be of benefit to him. This might be set up through work with a physical therapist.

In addition, medical management of his mood symptoms is strongly recommended. He may even be a good candidate for supportive counseling. Learning effective ways to try to control his anger and frustration might be helpful to him.

His mood and behavior together with his physical problems and cognitive difficulties make competitive employment at this point quite difficult. It is recommended that he obtain assistance in trying to reduce some of the effects of these variables, which might make him able to participate in a competitive employment on a more regular basis. Unfortunately, these variables are likely to prohibit him from consistently attending work or completing work requirements.

Neurologic examination would be recommended to further assess concerns regarding a potential progressive cognitive disorder. Brain imaging would certainly be recommended, which could include, but not be limited to MRI study, as well as amyloid PET imaging.

Claimants name: Darren Mickell
Appeal of T&P Benefit Denial

CONCLUSION

Based on the foregoing, Mr. Mickell is entitled to Total and Permanent Disability Benefits under the terms of the Plan for players who sustained such injuries as the direct result of their employment with the NFL. The Committee wrongfully denied benefits to Mr. Mickell and as such he has suffered extreme financial hardship and incurred significant attorneys' fees and costs. Additionally, the NFL and the Plan stand in violation of numerous federal and state laws.

Mr. Mickell demands approval of his claim for total and permanent disability benefits, the immediate commencement of benefits according to the appropriate benefits calculation, the amount of back benefits due to him, and reimbursement of the full amount of costs and attorneys' fees incurred by Mr. Mickell solely as the result of the Committee's wrongful denial of benefits. The attorney's fees specific to Mr. Mickell's claim to date amount to over $30,000, and the costs exceed $10,000.00.[10] Thus, The Plan can resolve this matter **by immediately releasing payment to the undersigned at 4151 Hollywood Blvd., Hollywood, Florida 33021** on Mr. Mickell's behalf to satisfy the full amount owed to him as of the date of this letter in combination with the immediate commencement of disability benefits from the date of this letter forward.[11]

In closing, please be advised that the undersigned will continue to submit supplemental evidence in support of Mr. Mickell's appeal as it becomes available and during the pendency of the Committee's appellate review of this claim. Additionally, in order for Mr. Mickell to have a full and fair review and opportunity to address any issues related to his benefits determination, **it is hereby requested that: any and all information, including medical consultation/reports, created by the Plan, the Committee, or its consultants during its appellate review of this claim that are relevant to a final benefit determination in this matter, be forwarded to the undersigned prior to any final benefit determination being made so that Mr. Mickell and/or his treating doctors may be granted the opportunity to review and respond to the new information**. The information being requested by the undersigned

[10] Please be advised that in the case of *Kamlet v. Prudential*, 2006 WL 1819406 (11th Circ. (Fla.)), the Court of Appeals affirmed the award of attorneys' fees and costs associated with Kamlet's LTD Claim with The Prudential, and held that pre-litigation and litigation attorneys' fees are recoverable in a disability claim subject to ERISA. The Court states "Prudential did not pay Kamlet his benefits; rather, in court, Prudential argued that it owed Kamlet no additional benefits at all . . . . Prudential . . . cannot seek refuge in a claim that it would have paid all the benefits up front [as] Prudential did not do this; in court, Prudential challenged Kamlet's right to any additional benefits." In stating this, the Court affirmed an award of attorneys' fees and costs to Kamlet in his ERISA disability claim because Prudential, in continually refusing to pay the disability claim, was the party responsible for the creation of both pre-litigation and litigation attorney's fees for Mr. Kamlet, which is analogous to Mr. Phelps's ERISA disability claim at-hand.

[11] Attached to this Appeal as Exhibit "8" is an Authorization to Forward Benefit Checks to DI Law Group signed by Mr. Mickell.

DG

includes any and all information not previously disclosed in response to my previous requests. This information is being requested pursuant to Mr. Mickell's rights under the Plan and under ERISA.

I look forward to working with you to resolve this claim administratively so that further legal action is not required.

Very truly yours,

Mindy L. Chmielarz,
For the Firm

Enclosures
cc: Alvaro Anillo via facsimile and Mail
Darren Mickell

Darren Mickell
Appeal and Supplemental Information
Claim for Total and Permanent Disability Benefits

Appeal Exhibit "1"

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

REGISTERED/RETURN RECEIPT

Certified Article Number
7196 9008 9111 8863 7509
SENDERS RECORD

September 27, 2013

Mr. Darren Mickell
9250 Chelsea Drive
Miramar, FL 33025

Re: Application for Total and Permanent Disability Benefits

Dear Mr. Mickell:

On September 27, 2013, the Disability Initial Claims Committee ("Committee") of the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") considered your application for total and permanent ("T&P") disability benefits. We regret to inform you that the Committee denied your application for T&P disability benefits. This letter describes the Committee's decision.

Relevant Plan Provisions

Plan section 5.1 provides that:

> "An Eligible Player whose application for total and permanent disability ("T&P") benefits is received by this Plan on or after September 1, 2011, who is determined by the Retirement Board or the Disability Initial Claims Committee to be totally and permanently disabled in accordance with Section 5.2, and who satisfies the other requirements of this Article 5, will receive a monthly T&P benefit in the amount described in Section 5.5 for the months described in Sections 5.8 and 5.9.
>
> For purposes of this Article, an Eligible Player is a Vested Inactive Player or an Active Player."

Plan section 5.2(a) provides that:

> "An Eligible Player who is not receiving monthly retirement benefits under Article 4 or Article 4A will be deemed to be totally and permanently disabled if the Retirement Board or the Disability Initial Claims Committee finds (1) that he has become totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit, but expressly excluding any disability suffered while in the military service of any country, and (2) that such condition is permanent. The

educational level and prior training of a Player will not be considered in determining whether such Player is "unable to engage in any occupation or employment for remuneration or profit." A Player will not be considered to be able to engage in any occupation or employment for remuneration or profit within the meaning of this Section 5.2 merely because such person is employed by the League or an Employer, manages personal or family investments, is employed by or associated with a charitable organization, is employed out of benevolence, or receives up to $30,000 per year in earned income. A disability will be deemed to be "permanent" if it has persisted or is expected to persist for at least twelve months from the date of its occurrence, excluding any reasonably possible recovery period."

Discussion

On September 27, 2013 the Committee denied your application for T&P benefits because you are currently employed. The Committee determined that your current employment is not associated with the League or an Employer, personal or family investments, a charitable organization, or out of benevolence. Therefore, the Committee found that you are not totally and permanently disabled under Plan section 5.2(a).

Appeal Rights

Attached to this letter is section 12.6 of the Plan, which governs your right to appeal the Committee's decision. You may appeal the Committee's decision to the Plan's Retirement Board by filing a written request for review with the Retirement Board at this office within 180 days of your receipt of this letter. You should also submit written comments, documents and any other information that you believe shows you qualify for these benefits. The Retirement Board will take into account all available information, regardless of whether that information was available or presented to the Committee. Please note that if the Retirement Board reaches an adverse decision on review, you may then bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, 27 U.S.C. §1132(a).

A copy of the Bert Bell/Pete Rozelle NFL Player Retirement Plan Summary Plan Description is enclosed. If you have any questions, please contact the Plan Office.

Very truly yours,

Paul Scott
Director of Disability Benefits
on behalf of the Disability Initial Claims Committee

prs

Enclosure

Darren Mickell
Appeal and Supplemental Information
Claim for Total and Permanent Disability Benefits

Appeal Exhibit "2"

TRANSMISSION VERIFICATION REPORT

TIME : 03/11/2014 12:21
NAME :
FAX :
TEL :
SER. # : U62708C1N224566

DATE, TIME	03/11 12:18
FAX NO./NAME	12026594503
DURATION	00:03:03
PAGE(S)	02
RESULT	OK
MODE	FINE

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fax 561.202.9194

FAX

To	Mr. Alvaro Anillo, Esquire	From	Mindy Chmielarz, Esquire
Fax	(202) 659-4503	Pages	2 (with cover page)
Phone		Date	March 11, 2014
Re	DARREN MICKELL Application for NFL PA Plan T&P Disability Benefits – Denial	CC	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: Please review and advise if the content does not meet with your agreement and understanding.

DILAW GROUP

Pauline Grisham, Smith, & Chmielarz, P.A.

March 11, 2014

Sent Via Facsimile: (202) 659-4503
Groom Law Group, Chartered
Attn.: Alvaro I. Anillo, Esquire
1701 Pennsylvania Avenue, NW
Washington, DC 20006-5811

RE: Name: Darren Mickell
Incident #: Appeal of Application for Total and Permanent Disability Benefits

Dear Mr. Anillo:

Thank you for sending a copy of the Plan and for acknowledging the timely filing of Mr. Mickell's appeal. As discussed, Mr. Mickell plans to send in medical records and other documents in support of his right to disability benefits under the Bert Bell/Pete Rozelle NFL Retirement Plan within the next few months. This correspondence is to confirm our conversation of February 4, 2104 wherein you agreed that Mr. Mickell's claim once timely filed, will remain open until such documents are provided and that all documents submitted will be considered during the review of his claim.

If the foregoing does not meet with your understanding or agreement, please contact me immediately. Should you have any questions or wish to further discuss this matter, please do not hesitate to contact me at (954) 989-9000.

Very truly yours,

Mindy L. Chmielarz,
For the Firm

cc: Paul Scott, Director of Disability Benefits via Facsimile

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fax 561.202.9194

Darren Mickell
Appeal and Supplemental Information
Claim for Total and Permanent Disability Benefits

Appeal Exhibit "3"

Send Result Report

KYOCERA

MFP

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Complete

Document: doc089773

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fax 561.202.9194

FAX

To	Megan Anderson, Benefits Coordinator	From	Mindy Chmielarz, Esquire
Fax	(410) 783-0041	Pages	4 (with cover page)
Phone		Date	June 4, 2014
Re	DARREN MICKELL Application for T&P	CC	

No.	Date and Time	Destination	Times	Type	Result	Resolution/ECM
001	06/04/14 16:20	14107830041	0°01'28"	FAX	OK	200x100 Normal/On

SCANNED

DI LAW GROUP

Paulino-Grisham, Smith, & Chmielarz, P.A.

June 4, 2014

Sent Via U.S. Mail & Facsimile: (410) 783-0041
Retirement Board for the
Bert Bell/Pete Rozelle NFL Player Retirement Plan
Attn.: Megan Anderson, Benefits Coordinator
200 St. Paul Street, Suite 2420
Baltimore, MD 21208-2008

RE: Name: Darren Mickell
Incident #: Application for Total and Permanent Disability Benefits

Dear Ms. Anderson:

Today I received the Notice of Neutral Physician's Evaluation scheduled with Dr. Chaim Arlosoroff in North Palm Beach for Monday June 9, 2014. **Please be advised that with less than 4 days' notice, Mr. Mickell is unable to attend the IME on that date.** Additionally, you indicated that written notice must be received by June 2, 2014 if there are body parts, other than those listed, which he would like the neutral physician to examine. As this Notice was not received until today, June 4, 2014, (I have enclosed the Fed Ex envelope showing that your Notice dated May 30, 2014 was sent on June 2, 2014 via 2 Day mail and received in our office on Wednesday, June 4th) we are unable to comply with that request. Accordingly, please reschedule the IME providing my client at least 2 weeks' notice.

Dr. Arlosoroff's medical office is located more than 70 miles from my client's home; thereby requiring my client to travel over 140 miles to attend this IME. Thus, if Mr. Mickell agrees to attend the IME with your chosen physician he needs sufficient time to make travel arrangements, as he may need someone to drive him.

Finally, please note that that **in accordance with his legal rights under Florida law, Mr. Mickell intends to have the IME videotaped by a 3rd, independent party.** I will arrange for the videographer and pay the expense. Accordingly, please advise the physician performing the IME that the exam will be videotaped. I can assure you as well as the examining physician that the videographer will not be intrusive. As you know, a videographer being present at Mr. Mickell' IME would not only help ensure that Mr. Mickell' rights are protected, but also that the NFL Retirement Plan's rights are protected. In the event that the written report resulting from said IME is ever called into question or challenged, all parties involved can simply refer to the videotape of the IME to resolve any dispute.

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fax 561.202.9194

Claimant: Darren Mickell
Re: Appeal of 9/27/13 Denial of Disability Benefits

Please further note that Florida courts have upheld the right of an individual to have a videographer or other recording third party present at an IME, which he or she must undergo at the risk of her benefits being terminated. The Florida Supreme Court has explained, "[w]e are persuaded by the fact that the doctor conducting the examination will provide a report to the insurance company . . . . [and] the report, including statements made by the insured to the doctor during the examination, and potentially the doctor's own live testimony about the examination, may be used against the insured. Therefore, it is unfair to place insureds in a position where anything they say may be used to terminate their benefits, but they are not allowed an opportunity to protect themselves."[1] The courts reason that **"by allowing the examination to be observed by a third party or videotaped, the potential harm to either party is reduced, not increased . . . ."**[2] The reason for this is that **"if there is no court reporter or other third party present at the examination . . . a disagreement can arise between the plaintiff and the doctor concerning the events of the IME . . . ."**[3] Additionally, it was specifically addressed by these courts that **"the concerns of physicians for conducting examinations without the distraction of third persons cannot outweigh the insured's rights."**[4] We trust that you will make every effort to accommodate Mr. Mickell' request and will allow for a videographer to be present at his IME without issue.

Finally, as I advised attorney Alvaro Anillo, we plan to submit all documents and information necessary to supplement Mr. Mickell's appeal by the end of this month. However, due to problems obtaining all of Mr. Mickell's past medical records and updated MRI reports it is possible that these documents will not be submitted to Mr. Anillo and the Board for the NFL Player Retirement Plan until July. It has already been confirmed that because Mr. Mickell's appeal was timely filed, further delays will not waive his right to an appeal or to have his claim reevaluated.

Should you have any questions or wish to further discuss this matter, please do not hesitate to contact me at (954) 989-9000.

Very truly yours,

Mindy L. Chmielarz,
For the Firm

cc: Alvaro Anillo via facsimile and Mail

[1] See U.S. Sec. Ins. Co. v. Cimino, 754 So.2d 697 (Fla. 2000).
[2] Cimino, 754 So.2d 697, See also, Byrd v. Southern Prestressed Concrete, Inc., 928 So.2d 455 (Fla. 1st DCA 2006)
[3] Id. See also Wilkins v. Palumbo, 617 So.2d 850, 852 (Fla. 2d DCA 1993).
[4] Cimino, 754 So.2d 697.

MICKELL-0834